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- **Faxing: 926-336-2490**

Name: ____Date: ________________________
Address: ____
Phone: _____________________________________Email: __________________________________
DOB: ____________________________________ Sex: __________________________________
Primary Physician: ______________________________ Phone:____________________________________

Current Therapist: ______________________________ Phone:____________________________________

Services you are seeking

☐Bariatric Surgery Clearance ☐Counseling or Therapy

☐Other Surgical Clearance ☐Substance Abuse Treatment

☐Gender Affirmation Evaluation ☐Medication Management/Treatment

☐Psychiatric Diagnosis

Complaint

What is your major complaint? ____
Start date: _________________ Have you previously suffered from this complaint?_________________
Previous therapist(s) seen for complaint: ____
Previous treatment for complaint: ____
Aggravating Factors: ____
Relieving Factors: ____

Current Symptoms (Check All That Apply)

☐Anxiety	☐Hallucinations	☐Irritability	☐Risky Activity
☐Appetite Issue	☐Loss of Interest	☐Panic Attacks	☐Sleep Changes
☐Avoidance	☐Excessive Energy	☐Racing Thoughts	☐Suspiciousness
☐Crying Spells	☐Fatigue	☐Guilt	
☐Depression	☐Impulsivity	☐Libido Changes	

Medical History

Exercise Frequency: _________________________________ Exercise Type (s):_______________________
Allergies: ____
What medications are you currently using? ____
Previous diagnoses/mental health treatment: ____
Previously treated by: ____
Previous medications: ____
Dates treated: ____

Previous medical conditions: ____

Previous surgeries: ____

Family History

Were you adopted? _______ If yes, at what age? _____________Foster care? _____ How long? ________

How is your relationship with your mother? ____
How is your relationship with your father? ____
Siblings and their ages: ____
Are your parents married? __________________ Divorced? ______________________________________
Did your parents remarry? _______________________ If yes? How old were you? _________________
If a patient is a minor under 18 years old and parents are divorced, who is medical decision maker?
____
Who raised you? _______________________________ Where did you grow up? _____________________
If patient is a minor under 18 years old, school attending? __________________ grade _____________
Special education?____
Family member medical conditions: ____
Family member mental conditions: ____
Treated with medication?____
Medications: ____

Early Development

How often did you move and where? ____
How old were you when you left home? ____
Have any immediate family members died? _________________ Who? __________________________
Have any completed suicide? _______________________________ Who? __________________________
Describe any neglect you suffered, and by whom: ____
Trauma suffered and by whom: ____
Abuse suffered and by whom: ____
Highest education level completed: __________ Date completed and location: ______________________
Have you ever served in the military? _________ If yes, where? ____________________________________
Date of service: ____________________________ Highest Rank achieved __________________________

Present Situation

Work: ☐Full-time ☐Part-time ☐Student ☐Unemployed ☐Disabled ☐Retired
Are you married?___________________________ If yes, date of marriage:_________________________
Are you divorced? ___________________________If yes, date of divorce: __________________________
Prior marriages? ______________________________ If yes, how many? ______________________________
What are your preferred pronouns? ______________

How is your relationship with your partner? ____
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Do you have children? ______________________Dates of Birth: _________________________________
How is your relationship with your child(ren)?____
List anyone else who lives with you: ____
Are you a member of a religion/spiritual group? ____
What is your level of involvement? ____
Have you ever been arrested? ________________________ When and why? _________________________
Are you under court ordered treatment? ____

Have You Ever Tried the Following? (Check All That Apply)

☐Heroin	☐Methamphetamines	☐ Cocaine	☐ Stimulants (Pills)
☐Ecstasy	☐Methadone	☐Tranquilizers	☐Pain Killers
☐Tobacco	☐Marijuana	☐Hallucinogens	☐Alcohol

If yes to any, list frequency/dates of use: ____
Have you ever been treated for drug/alcohol abuse? ___ If yes, when? ______________________________
For which substances? ____
Do you smoke cigarettes? _____If yes, how many per day? _______
Do you drink caffeinated beverages? ____If yes, how many per day? ______________________________

Have you ever abused prescription drugs? ______________ If yes, which ones? _______________________

Anything Else You Want the Doctor to Know

____
____
____
____
____
____
____

Signature ____ **Date** _________________________

Legal Guardian Name _______________________ **Signature**_______________________ **Date**__________

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